| STATEMEN      | T OF DEFICIENCIES         | X1) PROVIDER/SUPPLIER/CLIA  | (X2) M  | JLTIPLE CC  | NSTRUCTION  | (X3) DATE S | SURVEY             |
|---------------|---------------------------|---|---------|---|---|-------------|--------------------|
| AND PLAN      | OF CORRECTION             | IDENTIFICATION NUMBER:  | A. BUII | DING  |   | COMPL       | ETED               |
|               |                           | 155124  | B. WIN  |   |   | 03/08/2     | 011                |
| NAME OF E     | PROVIDER OR SUPPLIER      |   |         | STREET A  | ADDRESS, CITY, STATE, ZIP CODE  |             |                    |
|               |                           |   |         |   | MAIN ST   |             |                    |
| VERMILL       | LION CONVALESCE           | ENT CENTER  |         | CLINTO  | DN, IN47842   |             |                    |
| (X4) ID       |                           | STATEMENT OF DEFICIENCIES   |         | ID  | PROVIDER'S PLAN OF CORRECTION   |             | (X5)               |
| PREFIX<br>TAG | ``                        | ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)  |         | PREFIX<br>TAG   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)              | ΤE          | COMPLETION<br>DATE |
|               |                           | ·   | -       |   |   |             | DATE               |
| F0000         | This visit wa             | as for  | F00     | 00  | Submission of the plan of correction does not constitute  |             |                    |
|               | Recertification and State |   |         |   | admission or agreement by the   | е           |                    |
|               | Licensure su              | irvey.  |         |   | provider of the truth of facts<br>alleged or correction set forth<br>the statement of deficiencies. | on          |                    |
|               | Dates of sur              | Dates of survey: 3/1-4, 8/11  This plan of correction prepared and submittee of requirement under submittee of submittee |         | This plan of correction is prepared and submitted becaution of requirement under state and federal law.Please accept this | d   |             |                    |
|               | Facility num              | nber: 000052  |         |   | plan of correction as our credi<br>allegation of complaince   |             |                    |
|               | Provider nur              | mber: 155124  |         |   | allegation of complaince  |             |                    |
|               | AIM number: 100290340     |   |         |   |   |             |                    |
|               |                           | 1. 100290510  |         |   |   |             |                    |
|               | Survey team               | 1:  |         |   |   |             |                    |
|               | 1                         | ear, RN, TC 3/1, 4,   |         |   |   |             |                    |
|               | 8/11                      | , ,, , - ,  |         |   |   |             |                    |
|               | Mary Weyls                | . RN  |         |   |   |             |                    |
|               | Teresa Busk               |   |         |   |   |             |                    |
|               | Teresa Dusk               | c, Kiv  |         |   |   |             |                    |
|               | Census bed                | type:   |         |   |   |             |                    |
|               | SNF/NF: 10                | 00  |         |   |   |             |                    |
|               | Total: 100                |   |         |   |   |             |                    |
|               | 10141. 100                |   |         |   |   |             |                    |
|               | Census payo               | or type:  |         |   |   |             |                    |
|               | Medicare: 9               | )   |         |   |   |             |                    |
|               | Medicaid: 7               |   |         |   |   |             |                    |
|               | Other: 17                 | •   |         |   |   |             |                    |
|               |                           |   |         |   |   |             |                    |
|               | Total: 100                |   |         |   |   |             |                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000052

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J8XR11

Facility ID:

(X6) DATE

|               |                     | IDENTIFICATION NUMBER:  155124                           | A. BUILDING   | JNSTRUCTION  | COMPLETEI 03/08/2011 |                  |
|---------------|---------------------|--|---------------|--|----------------------|------------------|
|               |                     | 100124   | B. WING       |  |                      |                  |
| NAME OF P     | ROVIDER OR SUPPLIER |  |               | ADDRESS, CITY, STATE, ZIP CO   | DE                   |                  |
| VERMILL       | ION CONVALESCE      | ENT CENTER   |               | MAIN ST<br>DN, IN47842   |                      |                  |
| (X4) ID       |                     | TATEMENT OF DEFICIENCIES                                 | ID            | PROVIDER'S PLAN OF CORR  |                      | (X5)             |
| PREFIX<br>TAG |                     | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | PROPRIATE CO         | MPLETION<br>DATE |
| IAG           | REGULATORT OR       | ESC IDENTIF TING INFORMATION)                            | IAG           | ,  |                      | DATE             |
|               | Sample: 20          |  |               |  |                      |                  |
|               | _                   | .1. 1  |               |  |                      |                  |
|               | Supplementa         | ali. I   |               |  |                      |                  |
|               |                     |  |               |  |                      |                  |
|               | These defici        | encies also reflect                                      |               |  |                      |                  |
|               | state finding       | s in accordance  |               |  |                      |                  |
|               | with 410 IA         | C 16.2.  |               |  |                      |                  |
|               |                     |  |               |  |                      |                  |
|               | Onality revie       | ew completed   |               |  |                      |                  |
|               | 3-11-11             | ow completed   |               |  |                      |                  |
|               |                     | '11 DAI  |               |  |                      |                  |
|               | Cathy Emsw          | iller KN   |               |  |                      |                  |
|               |                     |  |               |  |                      |                  |
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|               |                     |  |               |  |                      |                  |

| STATEMEN      | T OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA            | (X2) MI | JLTIPLE CO    | ONSTRUCTION  | (X3) DATE SU | JRVEY              |
|---------------|--|---------------------------------------|---------|---------------|--|--------------|--------------------|
| AND PLAN      | OF CORRECTION  | IDENTIFICATION NUMBER:                | A. BUII | DING          |  | COMPLET      | TED                |
|               |  | 155124                                | B. WIN  |               |  | 03/08/201    | 11                 |
| NAME OF E     | PROVIDER OR SUPPLIER   |                                       |         | STREET A      | ADDRESS, CITY, STATE, ZIP CODE   |              |                    |
|               |  |                                       |         |               | MAIN ST  |              |                    |
| VERMILL       | ION CONVALESCE   | ENT CENTER                            |         | CLINTO        | DN, IN47842  |              |                    |
| (X4) ID       |  | TATEMENT OF DEFICIENCIES              |         | ID            | PROVIDER'S PLAN OF CORRECTION  |              | (X5)               |
| PREFIX<br>TAG | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |                                       |         | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | E (          | COMPLETION<br>DATE |
| F0224         |  | · · · · · · · · · · · · · · · · · · · | F02     |               | No residents were harmed.  | 2.           | 03/28/2011         |
| SS=D          | Based on interview and record review the facility failed to                          |                                       | 102     |               | All residents residing within the  |              | 05/20/2011         |
|               |  | •                                     |         |               | facility are at risk. Medication was replaced at the facility's co                     | ost          |                    |
|               | •  | appropriation of                      |         |               | for resident #16. See #3 below   | v            |                    |
|               | resident prop  | perty for 1 of 1                      |         |               | for corrective action. The nurs involved were suspended                                | ses          |                    |
|               | resident revi  | ewed, identified                      |         |               | immediately until the investiga  | tion         |                    |
|               | with misapp  | ropriation of                         |         |               | was completed. Both were terminated on 3/4/11. The                                     |              |                    |
|               | medication is  | n a supplemental                      |         |               | Attorney General was contacted   | ed           |                    |
|               | sample of 1,   | in that two staff                     |         |               | and a report filed for misappropriation of property.                                   |              |                    |
|               |  | ved medication                        |         |               | Ombudsman notified, along wind Adult Protective Services.3. T                          |              |                    |
|               | from the sup   |                                       |         |               | facility policy and procedures f   |              |                    |
|               | _  | edication for the                     |         |               | abuse prohibition, resident abu  |              |                    |
|               |  |                                       | 1       |               | and resident to resident abuse were reviewed and no change                             |              |                    |
|               | staff persons  |                                       |         |               | are indicated at this time (See  |              |                    |
|               | (Resident #1   | 6) (RN #3 and RN                      |         |               | attachment A). All staff were re-educatedon Abuse and "Dru                             | ın           |                    |
|               | #4)  |                                       |         |               | Diversion". All Phenergan was  | -            |                    |
|               |  |                                       |         |               | locked and accounted for and   |              |                    |
|               | Findings inc   | lude.                                 |         |               | continues to be counted every<br>shift as a controlled substance                       |              |                    |
|               |  | iuuv.                                 |         |               | The DON or her designee will   |              |                    |
|               | During inter   | viow of the                           |         |               | monitor to ensure shift-to=shift count is occurring daily on                           | ·            |                    |
|               |  |                                       |         |               | scheduled working days for 4   |              |                    |
|               | Corporate R  | N, Administrator                      |         |               | weeks, then weekly for 4 week then monthly for 3 months, the                           |              |                    |
|               | and DON (D   | Director of Nursing)                  |         |               | quarterly thereafter (See  | "            |                    |
|               | On 3/3/11 at   | 9:30 a.m., the                        |         |               | Attachment B).   |              |                    |
|               |  | or indicated they                     |         |               |  |              |                    |
|               |  | ready to send in a                    |         |               |  |              |                    |
|               |  | •                                     |         |               |  |              |                    |
|               |  | on an incident to                     |         |               |  |              |                    |
|               | the ISDH (Indiana State  |                                       |         |               |  |              |                    |
|               |  |                                       |         |               |  |              |                    |

|           | T OF DEFICIENCIES OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                  |             | NSTRUCTION  | (X3) DATE<br>COMPI |            |
|-----------|----------------------------------|--|------------------|-------------|---|--------------------|------------|
|           |                                  | 155124   | A. BUI<br>B. WIN | LDING<br>IG |   | 03/08/2            |            |
| NAME OF F | PROVIDER OR SUPPLIER             |  | 1                | _           | ADDRESS, CITY, STATE, ZIP CODE  | 1                  |            |
|           | LION CONVALESCE                  |  |                  | 1           | MAIN ST<br>DN, IN47842  |                    |            |
| (X4) ID   |                                  | TATEMENT OF DEFICIENCIES                             | -                | ID          | /IN, IINT/ OTZ  |                    | (X5)       |
| PREFIX    |                                  | CY MUST BE PERCEDED BY FULL                          |                  | PREFIX      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPR |                    | COMPLETION |
| TAG       |                                  | LSC IDENTIFYING INFORMATION)                         |                  | TAG         | DEFICIENCY)   |                    | DATE       |
|           | Department                       | of Health).  |                  |             |   |                    |            |
|           |                                  |  |                  |             |   |                    |            |
|           |                                  | dicated when she                                     |                  |             |   |                    |            |
|           | entered the facility on 3/28/11, |  |                  |             |   |                    |            |
|           | at approxima                     | ately 6:30 a.m., RN                                  |                  |             |   |                    |            |
|           | #14 indicate                     | d, QMA #15 had                                       |                  |             |   |                    |            |
|           | reported that                    | the evening RN                                       |                  |             |   |                    |            |
|           | (RN #3) had                      | entered the  |                  |             |   |                    |            |
|           | building at a                    | pproximately 3                                       |                  |             |   |                    |            |
|           | a.m., and had                    | d been in the  |                  |             |   |                    |            |
|           | medication of                    | eart on the  |                  |             |   |                    |            |
|           | north/west u                     | nit. The QMA had                                     |                  |             |   |                    |            |
|           | indicated wh                     | nen she ask him                                      |                  |             |   |                    |            |
|           | what he was                      | doing, he told the                                   |                  |             |   |                    |            |
|           | QMA that he                      | e was getting some                                   |                  |             |   |                    |            |
|           | medication f                     | for his wife (RN                                     |                  |             |   |                    |            |
|           |                                  | s ill at home. RN                                    |                  |             |   |                    |            |
|           | <i>'</i>                         | ed she had called                                    |                  |             |   |                    |            |
|           | RN #3 and to                     | old him he needed                                    |                  |             |   |                    |            |
|           |                                  | x the medication he                                  |                  |             |   |                    |            |
|           |                                  | ne facility. RN #14                                  |                  |             |   |                    |            |
|           |                                  | N, RN #3 brought                                     |                  |             |   |                    |            |
|           | back two Im                      | •  |                  |             |   |                    |            |
|           |                                  | al) tablets and two                                  |                  |             |   |                    |            |
|           | Phenergan (a                     | •  |                  |             |   |                    |            |
|           |                                  |  |                  |             |   |                    |            |
|           |                                  |  |                  |             |   |                    |            |

|             | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) M           | ULTIPLE CO  | NSTRUCTION  | (X3) DATE S<br>COMPL |            |
|-------------|----------------------------------|--|------------------|-------------|---|----------------------|------------|
| 11112 12111 | or columberion                   | 155124   | A. BUI<br>B. WIN | LDING<br>IG |   | 03/08/2              |            |
| NAME OF F   | PROVIDER OR SUPPLIER             |  | D. WII           | _           | ADDRESS, CITY, STATE, ZIP CODE  | 1                    |            |
|             | LION CONVALESCE                  |  |                  | 1           | MAIN ST<br>DN, IN47842  |                      |            |
| (X4) ID     |                                  | TATEMENT OF DEFICIENCIES                             |                  | ID          | JN, IN47042   |                      | (X5)       |
| PREFIX      |                                  | CY MUST BE PERCEDED BY FULL                          |                  | PREFIX      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ATE                  | COMPLETION |
| TAG         |                                  | LSC IDENTIFYING INFORMATION)                         | -                | TAG         | DEFICIENCY)   |                      | DATE       |
|             | tablets.                         |  |                  |             |   |                      |            |
|             |                                  |  |                  |             |   |                      |            |
|             |                                  | dicated she called                                   |                  |             |   |                      |            |
|             | l '                              | had him come in to                                   |                  |             |   |                      |            |
|             | the facility o                   | on 2/28/11. The                                      |                  |             |   |                      |            |
|             | DON indicate                     | ted RN #3  |                  |             |   |                      |            |
|             | indicated he                     | was working on                                       |                  |             |   |                      |            |
|             | the evening                      | shift on 2/27/11,                                    |                  |             |   |                      |            |
|             | and began fe                     | eling very sick.                                     |                  |             |   |                      |            |
|             | RN #3 indicates                  | ated RN #4 gave                                      |                  |             |   |                      |            |
|             | him a syring                     | e with phenergan,                                    |                  |             |   |                      |            |
|             | and he gave                      | himself the  |                  |             |   |                      |            |
|             | injection. R                     | N #3 then  |                  |             |   |                      |            |
|             | indicated his                    | s wife (RN #4)                                       |                  |             |   |                      |            |
|             | became ill in                    | the early a.m., and                                  |                  |             |   |                      |            |
|             | that was the                     | reason he  |                  |             |   |                      |            |
|             | re-entered th                    | e facility and took                                  |                  |             |   |                      |            |
|             | the medication                   | •  |                  |             |   |                      |            |
|             |                                  | took a vial of                                       |                  |             |   |                      |            |
|             | Phenergan, t                     | wo Immodium  |                  |             |   |                      |            |
|             | _                                | wo Phenergan   |                  |             |   |                      |            |
|             |                                  | #3 indicated he                                      |                  |             |   |                      |            |
|             |                                  | tablets, but was                                     |                  |             |   |                      |            |
|             |                                  | urn the vial of                                      |                  |             |   |                      |            |
|             | phenergan d                      |  |                  |             |   |                      |            |
|             | F                                |  |                  |             |   |                      |            |

PRINTED: 04/01/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124 |  | (X2) MULTIPLE CO  A. BUILDING  B. WING  | INSTRUCTION         | (X3) DATE SURVEY COMPLETED 03/08/2011  |          |                            |
|---|--|---|---------------------|--|----------|----------------------------|
|   | PROVIDER OR SUPPLIER   |   | STREET A<br>1705 S  | ADDRESS, CITY, STATE, ZIP CODE<br>MAIN ST<br>DN, IN47842   | <b>I</b> |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | O BE     | (X5)<br>COMPLETION<br>DATE |
|   | already adm  | inistered the to his wife. The  |                     |  |          |                            |
|   |  | ted the medication  |                     |  |          |                            |
|   | l  | ten from Resident   |                     |  |          |                            |
|   | #16's medica   | ation supply.   |                     |  |          |                            |
|   | policy titled PROHIBITI AND INVERTIES TO THE AND IN | ON, REPORTING STIGATION", 3/1/11 at 2 p.m., ministrator, on indicated riation of Resident edeliberate ent, exploitation or 1, temporary or 1, |                     |  |          |                            |

000052

|               |                      | IDENTIFICATION NUMBER:  155124                           | A. BUILDING      | UNSTRUCTION   | COMP<br>03/08/2 | LETED           |  |  |
|---------------|----------------------|--|------------------|---|-----------------|-----------------|--|--|
|               |                      | 100127   | B. WING          | ADDRESS, CITY, STATE, ZIP CODI                            |                 |                 |  |  |
| NAME OF F     | PROVIDER OR SUPPLIER |  | l l              | MAIN ST   | ٺ               |                 |  |  |
|               | ION CONVALESCE       |  | CLINTON, IN47842 |   |                 |                 |  |  |
| (X4) ID       |                      | TATEMENT OF DEFICIENCIES                                 | ID               | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU | TION<br>LD BE   | (X5)            |  |  |
| PREFIX<br>TAG | · ·                  | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG    | CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)               | ROPRIATE        | COMPLETION DATE |  |  |
| _             | 3.1-28(a)            | ,                  |                  |   |                 |                 |  |  |
|               | $\int .1-20(a)$      |  |                  |   |                 |                 |  |  |
|               |                      |  |                  |   |                 |                 |  |  |
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| STATEMEN          | T OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA                             | (X2) MU     | JLTIPLE CC   | ONSTRUCTION   | (X3) DATE SURVEY   |  |
|-------------------|--|--|-------------|--|---|--------------------|--|
| AND PLAN          | OF CORRECTION  | IDENTIFICATION NUMBER:                                 | A. BUILDING |  |   | COMPLETED          |  |
|                   |  | 155124   | B. WING     | 3 <u> </u>   |   | 03/08/2011         |  |
| NAME OF F         | PROVIDER OR SUPPLIER   |  | •           |  | ADDRESS, CITY, STATE, ZIP CODE  |                    |  |
| \/EDMILI          | IONI CONIVAL ECCE  | INT OFNITED  |             |  | MAIN ST   |                    |  |
|                   | LION CONVALESCE  |  |             |  | ON, IN47842   |                    |  |
| (X4) ID<br>PREFIX |  | TATEMENT OF DEFICIENCIES  CV MUST BE DED CEDED BY FULL |             | ID<br>PREFIX   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE          | (X5)<br>COMPLETION |  |
| TAG               | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  | TAG         |  | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)                              | DATE               |  |
| F0225             | Based on int   | Based on interview and record                          |             | 25   | The facility will ensure this   | 03/28/2011         |  |
| SS=D              | review the facility failed to  |  |             | requirement is met through the following corrective measures:  |   | 1.                 |  |
|                   | ensure all all   | leged violations                                       |             |  | No residents were harmed.2. residents residing within the                   | All                |  |
|                   | including mi   | sappropriation of                                      |             |  | facility are at risk Medication version replaced at the facility's cost for |                    |  |
|                   | resident's pro   | operty were  |             |  | resident #16. See #3 below fo   | I                  |  |
|                   | reported imp   | nediately to the                                       |             |  | corrective action. The nurses involved were suspended                       |                    |  |
|                   | Administrato   | or for 1 of 1  |             |  | immediately until the investiga   | tion               |  |
|                   | residents rev  | riewed in a  |             |  | was completed. Both were terminated on 3/4/11. The                          |                    |  |
|                   | supplementa  | l sample of 1, in                                      |             |  | Attorney General was contacted and a report filed for                       | ed                 |  |
|                   | that staff per   | •  |             |  | misappropriation of property.   |                    |  |
|                   | •  | out of resident  |             |  | Ombudsman notified, along wind Adult Protective Services.3. T               | I                  |  |
|                   | #16's medica   | ation supply and                                       |             |  | facility policy and procedures f abuse prohibition, resident abu            |                    |  |
|                   |  | trator was not made                                    |             |  | and resident to resident abuse  |                    |  |
|                   | aware of the   | incident until   |             |  | were reviewed and no change are indicated at this time (See                 | l l                |  |
|                   | entering the   | facility.(RN #3 and                                    |             |  | Attachment C). Staff were   |                    |  |
|                   | RN #4).  | <b>3</b> (   |             |  | re-educated on Abuse, in particular ensuring all potentia                   | ı                  |  |
|                   | Findings include:  |  |             | violations are reported immediately to the facility administrator. The DON will question 5 random license staff regarding abuse at the |   |                    |  |
|                   | During inter   | view of the  |             |  | following intervals: 5 per week four weeks, then 5 per month to             | for                |  |
|                   | Corporate R  | N, Administrator                                       |             |  | three months, then 5 per quart (See Attachment D). The                      | ter                |  |
|                   | _  | Pirector of Nursing)                                   |             |  | Administrator or her designee   | I                  |  |
|                   | `  | 9:30 a.m., the   |             |  | do same but with 5 non-license employees (See Attachment E                  | l l                |  |
|                   | Administrator indicated they   |  |             |  | the same intervals to ensure  |                    |  |
|                   |  | ready to send in a                                     |             |  | vilations are being reported immediately.4. The findings of                 | f                  |  |

|            | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) M           | ULTIPLE CO  | ONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|------------|---------------------------------|--|------------------|-------------|---|-------------------------------|--|
| THIS TELLY | or colucterior.                 | 155124   | A. BUI<br>B. WIN | LDING<br>IG |   | 03/08/2011                    |  |
| NAME OF F  | PROVIDER OR SUPPLIER            |  | <i>D.</i> WII    |             | ADDRESS, CITY, STATE, ZIP CODE  |                               |  |
|            | LION CONVALESCE                 |  |                  | 1           | MAIN ST<br>DN, IN47842  |                               |  |
| (X4) ID    |                                 | TATEMENT OF DEFICIENCIES                             |                  | ID          | JN, 1147042<br>   | (X5)                          |  |
| PREFIX     |                                 | CY MUST BE PERCEDED BY FULL                          |                  | PREFIX      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | COMPLETION                    |  |
| TAG        |                                 | LSC IDENTIFYING INFORMATION)                         | -                | TAG         | these audits will be reviewed   | DATE                          |  |
|            | 5 day report on an incident to  |  |                  |             | during the facility's quarterly   |                               |  |
|            | the ISDH (Ir                    |  |                  |             | Quality Assurance meetings a the plan of action adjusted  | and                           |  |
|            | Department                      | of Health).  |                  |             | accordingly.5. The above  |                               |  |
|            | The DON indicated when she      |  |                  |             | corrective actions will be completed on or before 3/28/1  | 1.                            |  |
|            |                                 |  |                  |             |   |                               |  |
|            |                                 | facility on 2/28/11,                                 |                  |             |   |                               |  |
|            |                                 | ately 6:30 a.m., RN                                  |                  |             |   |                               |  |
|            | #14 indicated                   | d, QMA #15 had                                       |                  |             |   |                               |  |
|            | reported that the evening RN    |  |                  |             |   |                               |  |
|            | (RN #3) had                     | entered the  |                  |             |   |                               |  |
|            | building at a                   | pproximately 3                                       |                  |             |   |                               |  |
|            | a.m., and had                   | d been in the  |                  |             |   |                               |  |
|            | medication of                   | eart on the  |                  |             |   |                               |  |
|            | north/west u                    | nit. The QMA had                                     |                  |             |   |                               |  |
|            | indicated wh                    | nen she ask him                                      |                  |             |   |                               |  |
|            | what he was                     | doing, he told the                                   |                  |             |   |                               |  |
|            | QMA that he                     | e was getting some                                   |                  |             |   |                               |  |
|            | medication f                    | For his wife (RN                                     |                  |             |   |                               |  |
|            |                                 | s ill at home. RN                                    |                  |             |   |                               |  |
|            | <b>_</b>                        | ed she had called                                    |                  |             |   |                               |  |
|            | RN #3 and to                    | old him he needed                                    |                  |             |   |                               |  |
|            | to bring back                   | k the medication he                                  |                  |             |   |                               |  |
|            |                                 | ne facility. RN #14                                  |                  |             |   |                               |  |
|            |                                 | N, RN #3 brought                                     |                  |             |   |                               |  |
|            | back two Im                     | ,  |                  |             |   |                               |  |
|            |                                 |  |                  |             |   |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155124 |  | A. BUILDING   | CONSTRUCTION        | COM   | (X3) DATE SURVEY COMPLETED 03/08/2011 |   |
|---|--|---|---------------------|---|---------------------------------------|---|
|   | PROVIDER OR SUPPLIER   |   | 1705                | T ADDRESS, CITY, STATE, ZIP C<br>S MAIN ST<br>TON, IN47842                                    |                                       | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | HOULD BE                              | (X5)<br>COMPLETION<br>DATE              |
|   | (anti-diarrhe  | ea) tablets and two   |                     |   |                                       |   |
| Phenergan (anti-nausea)   |  |   |                     |   |                                       |   |
|   | tablets.   |   |                     |   |                                       |   |
|   | from Reside supply.  The DON in Administrate notified of the supplemental content of t | nad been taken nt #16's medication  dicated she and the or had not been he incident until the building on |                     |   |                                       |   |
|   | policy titled<br>Unusual Occ<br>State", on 3/<br>provided by<br>the policy in<br>Administrate<br>notified immalleged viola   | currences to the 1/1/11 at 2 p.m., the Administrator, adicated the  |                     |   |                                       |   |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155124 |                                    | (X2) MULTIPLE CC<br>A. BUILDING<br>B. WING  | NSTRUCTION          | I   | E SURVEY<br>PLETED<br>2011 |                            |
|---|------------------------------------|---|---------------------|---|----------------------------|----------------------------|
|   | PROVIDER OR SUPPLIER               |   | STREET A<br>1705 S  | ADDRESS, CITY, STATE, ZIP COM<br>MAIN ST<br>DN, IN47842   | DE                         |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SHE<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | OULD BE                    | (X5)<br>COMPLETION<br>DATE |
| l   | property.  On 3/4/11 at DON indica |   | 1                   | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE AP   | OULD BE                    |                            |
|   |                                    |   |                     |   |                            |                            |

| STATEMEN          | T OF DEFICIENCIES             | X1) PROVIDER/SUPPLIER/CLIA  | (X2) MI | JLTIPLE CO   | ONSTRUCTION  | (X3) DATE SURVEY   |
|-------------------|-------------------------------|---|---------|--------------|--|--------------------|
| AND PLAN          | OF CORRECTION                 | IDENTIFICATION NUMBER:  | A. BUII | LDING        |  | COMPLETED          |
|                   |                               | 155124  | B. WIN  |              |  | 03/08/2011         |
| NAME OF F         | PROVIDER OR SUPPLIER          |   |         |              | ADDRESS, CITY, STATE, ZIP CODE   |                    |
| \/EDMILI          | LION CONVALESCE               |   |         |              | MAIN ST  |                    |
|                   |                               |   |         |              | ON, IN47842  |                    |
| (X4) ID<br>PREFIX |                               | TATEMENT OF DEFICIENCIES  CV MUST BE DEPICEDED BY FULL                                  |         | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE   | (X5)<br>COMPLETION |
| TAG               | `                             | (EACH DEFICIENCY MUST BE PERCEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |         | TAG          | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)   | DATE               |
| F0226             | Based on int                  | erview and record   | F02     | 26           | The facility will ensure this requirement is met through the   | 03/28/2011         |
| SS=D              | review the facility failed to |   |         |              | following corrective measures:   | 1.                 |
|                   | implement p                   | olicies concerning  |         |              | No residents were harmed.2. residents residing within the  | All                |
|                   | misappropria                  | ation of resident   |         |              | facility are at risk. Medication was replaced at the facility's compared to the facility's compared to the facility of the fac | ost                |
|                   |                               | well as reporting   |         |              | for resident #16. See #3 below<br>for corrective action. The nurs  | w                  |
|                   | •                             | of 1 resident in a  |         |              | involved were suspended  |                    |
|                   | * *                           | ll sample of 1, in  |         |              | immediately until the investiga was completed. Both were   | tion               |
|                   | that staff too                | k medication from   |         |              | terminated on 3/4/11. The  |                    |
|                   | resident #16                  | 's medication   |         |              | Attorney General was contacted and a report filed for  | ed                 |
|                   | supply and the                | he Administrator  |         |              | misappropriation of property.  |                    |
|                   |                               | nediately notified  |         |              | Ombudsman notified, along w Adult Protective Services.3. T   |                    |
|                   |                               | ation was taken   |         |              | facility policy and procedures to abuse prohibition, resident about  |                    |
|                   | from residen                  | at #16's medication   |         |              | and resident to resident abuse   | .                  |
|                   | supply. (Res                  | ident #16) (RN #3   |         |              | were reviewed and no change are indicated at this time (See  |                    |
|                   | and RN #4)                    |   |         |              | Attachment A). Staff were re-educated on Abuse, in   |                    |
|                   | Findings include:             |   |         |              | particular ensuring all potential violations are reported immediately to the facility Administrator. The DON will question 5 random licensed st  |                    |
|                   | During inter                  | view of the DON   |         |              | regarding abuse at the following intervals: 5 per week for four  |                    |
|                   | on 3/2/11 at                  | 9:30 a.m., the  |         |              | weeks, then 5 per month for the  | nree               |
|                   | DON indicat                   | ted when she  |         |              | months, then 5 per quarter (Se Attachment C). The  | ee                 |
|                   | entered the f                 | facility on 2/28/11,  |         |              | Administrator or her designee do same but with 5 non-licens  |                    |
|                   | at approxima                  | ately 6:30 a.m., RN   |         |              | employees (See Attachment C  |                    |
|                   | #14 indicate                  | d, QMA #15 had  |         |              | the same intervals to ensure violations are being reported   |                    |
|                   | reported that                 | t the evening RN  |         |              | immediately.4. The findings o  | f                  |
|                   |                               |   |         |              | l  |                    |

PRINTED: 04/01/2011 FORM APPROVED OMB NO. 0938-0391

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |        | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |            | (X3) DATE SURVEY COMPLETED |  |
|--------------------------|---|---|--------|---|--|------------|----------------------------|--|
|                          |   | 155124  | B. WIN |   |  | 03/08/2011 |                            |  |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | •      | 1                                       | ADDRESS, CITY, STATE, ZIP CODE  MAIN ST  | •          |                            |  |
| VERMILL                  | LION CONVALESCE   | ENT CENTER  |        | 1                                       | DN, IN47842  |            |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |        | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE         | (X5)<br>COMPLETION<br>DATE |  |
|                          | (RN #3) had entered the   |   |        |   | these audits will be reviewed during the facility's quarterly  |            |                            |  |
|                          | building at a   | pproximately 3  |        |   | Quality Assurance meetings a   | and        |                            |  |
|                          | a.m., and had   | d been in the   |        |   | the plan of action adjusted accordingly.5. The above   |            |                            |  |
|                          | medication of   | cart on the   |        |   | corrective actions will be completed on or before 3/28/1   | 11         |                            |  |
|                          | north/west u  | nit. The QMA had  |        |   | ,  |            |                            |  |
|                          | indicated wh  | nen she ask him   |        |   |  |            |                            |  |
|                          | what he was   | doing, he told the  |        |   |  |            |                            |  |
|                          | QMA that he   | e was getting some  |        |   |  |            |                            |  |
|                          | medication f  | for his wife (RN  |        |   |  |            |                            |  |
|                          | #4) who was   | s ill at home. RN   |        |   |  |            |                            |  |
|                          | #14 indicate  | ed she had called   |        |   |  |            |                            |  |
|                          | RN #3 and to  | old him he needed   |        |   |  |            |                            |  |
|                          | to bring back   | k the medication he   |        |   |  |            |                            |  |
|                          | took from th  | ne facility. RN #14   |        |   |  |            |                            |  |
|                          | told the DOI  | N, RN #3 brought  |        |   |  |            |                            |  |
|                          | back two Im   | modium  |        |   |  |            |                            |  |
|                          | (anti-diarrhe   | a) tablets and two  |        |   |  |            |                            |  |
|                          | Phenergan (a  | anti-nausea)  |        |   |  |            |                            |  |
|                          | tablets.  |   |        |   |  |            |                            |  |
|                          |   |   |        |   |  |            |                            |  |
|                          | The DON in  |   |        |   |  |            |                            |  |
|                          | medication h  | nad been taken  |        |   |  |            |                            |  |
|                          | from Reside   | nt #16's medication   |        |   |  |            |                            |  |
|                          | supply.   |   |        |   |  |            |                            |  |
|                          |   |   |        |   |  |            |                            |  |
|                          |   |   |        |   |  |            |                            |  |

000052

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155124 |  |  | (X2) MULTIPLE CO  A. BUILDING  B. WING | NSTRUCTION  | (X3) DATE<br>COMP<br>03/08/2 | LETED                      |
|--|--|--|--|---|------------------------------|----------------------------|
|  | PROVIDER OR SUPPLIER   |  | 1705 S                                 | ADDRESS, CITY, STATE, ZIP CODE<br>MAIN ST<br>DN, IN47842  | 3                            |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | LD BE                        | (X5)<br>COMPLETION<br>DATE |
|  | The DON in   | dicated she and the  |  |   |                              |                            |
|  | Administrate   | or had not been  |  |   |                              |                            |
|  | notified of the  | ne incident until  |  |   |                              |                            |
|  | they entered   | the building on  |  |   |                              |                            |
|  | 2/28/11 at 6:  | 30 a.m.  |  |   |                              |                            |
|  | policy titled PROHIBITI AND INVEST received on from the Add documentatis "Misappropring Property-the misplacement the wrongful permanent under the second se | ON, REPORTING STIGATION", 3/1/11 at 2 p.m., ministrator, on indicated riation of Resident edeliberate ent, exploitation or l, temporary or se of a resident's or money without |  |   |                              |                            |
|  | policy titled<br>Unusual Occ   | "Reporting currences to the 1/11 at 2 p.m.,  |  |   |                              |                            |

PRINTED: 04/01/2011 FORM APPROVED OMB NO. 0938-0391

| l                        | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155124                                 | (X2) MULTIPLE CO  A. BUILDING  B. WING | NSTRUCTION  | (X3) DATE<br>COMP<br>03/08/2 | LETED                      |
|--------------------------|----------------------------------|---|--|---|------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIER             |   | 1705 S                                 | ADDRESS, CITY, STATE, ZIP CODE<br>MAIN ST<br>DN, IN47842  | 3                            |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | LD BE                        | (X5)<br>COMPLETION<br>DATE |
|                          | provided by                      | the Administrator,  |  |   |                              |                            |
|                          | the policy in                    | idicated the  |  |   |                              |                            |
|                          | Administrate                     | or would be   |  |   |                              |                            |
|                          |                                  | nediately of an   |  |   |                              |                            |
|                          |                                  | ation involving   |  |   |                              |                            |
|                          | misappropri                      | ation of resident   |  |   |                              |                            |
|                          | property.                        |   |  |   |                              |                            |
|                          | 2/4/44                           | 2.00  |  |   |                              |                            |
|                          |                                  | 3:00 p.m. the   |  |   |                              |                            |
|                          |                                  | ted the nurses were   |  |   |                              |                            |
|                          | terminated of                    | on 3/4/11.  |  |   |                              |                            |
|                          | 3.1-28(a)                        |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |
|                          |                                  |   |  |   |                              |                            |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      | (X2) MULTIPLE CONSTRUCTION                               |                                |               | (X3) DATE S<br>COMPL  |      |                    |
|---|----------------------|--|--------------------------------|---------------|---|------|--------------------|
| THETETAL  | or connection        | 155124   | A. BUILDING B. WING 03/08/2011 |               |   |      |                    |
|   |                      |  | B. WIN                         |               | ADDRESS, CITY, STATE, ZIP CODE                                      |      |                    |
| NAME OF F   | PROVIDER OR SUPPLIER |  |                                |               | MAIN ST   |      |                    |
|   | ION CONVALESCE       |  |                                | CLINT         | ON, IN47842   |      |                    |
| (X4) ID<br>PREFIX   |                      | TATEMENT OF DEFICIENCIES                                 |                                | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE  |      | (X5)               |
| TAG   | `                    | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |                                | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)                      | ΓE   | COMPLETION<br>DATE |
| F0323   | Based on ob          |  | F03                            |               | The facility must ensure that the                                   |      | 03/28/2011         |
| SS=D  |                      | nd record review,  |                                |               | resident environment remains free of accident hazards as is         | as   |                    |
|   | the facility fa      | ailed to ensure  |                                |               | possible; and each resident receives adequate supervision           | 1    |                    |
|   | safety for 3 of      | of 3 residents   |                                |               | and assistive devices to preve accidents. The facility feels it has |      |                    |
|   | observed trai        | nsferred with  |                                |               | met this requirement through t                                      | he   |                    |
|   | mechanical l         | ifts in a sample of                                      |                                |               | following corrective measures: Resident # 101,#7, and #61           | 1.   |                    |
|   | 20 in that ma        | anufacturer's  |                                |               | suffered no actual harm.2. Residents who require the use            | v of |                    |
|   | guidelines w         | ere not followed.  |                                |               | a mechanical lift have the  | , 01 |                    |
|   | _                    | 101, #7, 61]   |                                |               | potential to be affected.3. The                                     | ;    |                    |
|   |                      | 101, ", ", "   |                                |               | policy and procedure for mechanical lift use (See                   |      |                    |
|   | T: 1:                | 1 1  |                                |               | Attachment D) and the lift  |      |                    |
|   | Findings inc         | iude:  |                                |               | manufacturer's instructions we reviewed. The policy requires        |      |                    |
|   |                      |  |                                |               | changes at this time. Licensed                                      | d    |                    |
|   | 1. On 3/1/11         | at 11:40 a.m.,   |                                |               | and non-licensed nursing staff were re-educated regarding           |      |                    |
|   | with LPN #1          | 1, Resident #101   |                                |               | both(See Attachment E) The  |      |                    |
|   | was identifie        | ed as utilized a   |                                |               | Director of Nursing or designed will complete competency che        |      |                    |
|   | mechanical l         | ift for transfers.                                       |                                |               | offs for Mechanical Lift three                                      |      |                    |
|   |                      |  |                                |               | times daily on scheduled work days for 2 weeks, then daily or       |      |                    |
|   | <br>  On 3/8/11 at   | 11:00 a.m., CNAs   |                                |               | scheduled work days for two   | '    |                    |
|   |                      | were observed to   |                                |               | weeks, then weekly for four weeks, then monthly for two             |      |                    |
|   |                      |  |                                |               | months, then quarterly (See   |      |                    |
|   |                      | dent #101 from the                                       |                                |               | Attachment F).4. The findings these audits will be reviewed         | of   |                    |
|   | bed to wheel         | chair with the   |                                |               | during the facility's quarterly                                     |      |                    |
|   | Invacare Rel         | iant 450   |                                |               | Quality Assurance meetings a  | nd   |                    |
|   | mechanical l         | ift. The Resident  |                                |               | the plan of action adjusted accordingly.5. The above                |      |                    |
|   | was observed         | d positioned on the                                      |                                |               | corrective measures will be completed on or before 3/28/1           | ,    |                    |
|   | lift sling in b      | ed. The CNAs   |                                |               | Sompleted on or before 3/20/1                                       | "    |                    |
|   |                      |  |                                |               |   |      |                    |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      |                              |                  | NSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |            |   |
|--|----------------------|------------------------------|------------------|-------------|---|------------|---|
|  |                      | 155124                       | A. BUI<br>B. WIN | LDING<br>IG |   | 03/08/2011 |   |
| NAME OF I  | PROVIDER OR SUPPLIER |                              | P. (12)          |             | ADDRESS, CITY, STATE, ZIP CODE  |            |   |
|  | LION CONVALESCE      |                              |                  | 1           | MAIN ST<br>DN, IN47842  |            |   |
| (X4) ID  |                      | TATEMENT OF DEFICIENCIES     |                  | ID          | JN, 1N47 042  | (X5)       |   |
| PREFIX   |                      | CY MUST BE PERCEDED BY FULL  |                  | PREFIX      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | COMPLETIO  | N |
| TAG  | REGULATORY OR        | LSC IDENTIFYING INFORMATION) | _                | TAG         | DEFICIENCY)   | DATE       |   |
|  | were observe         | ed to attach the             |                  |             |   |            |   |
|  | sling to the l       | ift. The fabric was          |                  |             |   |            |   |
|  | observed to          | be torn on two of            |                  |             |   |            |   |
|  | four corners         | of the sling that            |                  |             |   |            |   |
|  | attach to the        | lift. The CNAs               |                  |             |   |            |   |
|  | indicated the        | ey had not noticed           |                  |             |   |            |   |
|  | the torn fabr        | ic. CNA #12 exited           |                  |             |   |            |   |
|  | the room to          | obtain another               |                  |             |   |            |   |
|  | sling. The se        | econd sling was              |                  |             |   |            |   |
|  | observed to          | have a worn,                 |                  |             |   |            |   |
|  | frayed loop          | [hook]. CNA #12              |                  |             |   |            |   |
|  | -                    | e had not noticed            |                  |             |   |            |   |
|  |                      | ted the room to              |                  |             |   |            |   |
|  | obtain anoth         |                              |                  |             |   |            |   |
|  |                      | or simp.                     |                  |             |   |            |   |
|  | On 3/8/11 at         | 11:15 a.m., CNAs             |                  |             |   |            |   |
|  |                      | indicated both               |                  |             |   |            |   |
|  |                      |                              |                  |             |   |            |   |
|  | ends of the b        | •                            |                  |             |   |            |   |
|  | i received two       | new lift pads.               |                  |             |   |            |   |
|  | ΛΩς                  | unin a Dani dana             |                  |             |   |            |   |
|  | 1 ^                  | oning Resident               |                  |             |   |            |   |
|  |                      | third lift pad, the          |                  |             |   |            |   |
|  | •                    | ached to the lift.           |                  |             |   |            |   |
|  | With the bas         | e of the lift under          |                  |             |   |            |   |
|  | the bed in cl        | osed position, the           |                  |             |   |            |   |
|  |                      |                              |                  |             |   |            |   |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  |                  | NSTRUCTION          | (X3) DATE<br>COMPI  |         |                            |
|---|---|--|------------------|---------------------|---|---------|----------------------------|
|   |   | 155124   | A. BUI<br>B. WIN | LDING<br>NG         |   | 03/08/2 | 011                        |
| NAME OF I   | PROVIDER OR SUPPLIER  |  | •                |                     | DDRESS, CITY, STATE, ZIP CODE  MAIN ST  | •       |                            |
| VERMILL   | LION CONVALESCE   | ENT CENTER   |                  | 1                   | N, IN47842  |         |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  |                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤΕ      | (X5)<br>COMPLETION<br>DATE |
|   | rear casters v  | were locked. The   |                  |                     |   |         |                            |
|   | resident was  | raised several   |                  |                     |   |         |                            |
|   | mattress. The away from the the resident of the mast and position transwheelchair, was opened wheelchair to locked. The turned toward | the surface of the ne lift was pulled he bed, and with perpendicular to d in the elevated sferred to the The base of the lift around the he rear castors resident was d the mast and to the wheelchair.    |                  |                     |   |         |                            |
|   | was reviewe<br>p.m. The M<br>[MDS] asses<br>on 12/7/10, of<br>as required to<br>two for transformation-ambulator<br>order [no data    | ol's clinical record<br>d on 3/1/11 at 2:45<br>inimum Data Set<br>ssment, completed<br>coded the resident<br>otal assistance of<br>sfers,<br>cory. A physician's<br>te] was noted of<br>er with assistance |                  |                     |   |         |                            |

|                          |                             | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155124                           | (X2) MULTIPLE CC  A. BUILDING  B. WING                                  | NSTRUCTION   | (X3) DATE SURVEY COMPLETED 03/08/2011 |   |  |  |
|--------------------------|-----------------------------|---|---|--|---------------------------------------|---|--|--|
|                          | PROVIDER OR SUPPLIEF        |   | STREET ADDRESS, CITY, STATE, ZIP CODE  1705 S MAIN ST  CLINTON, IN47842 |  |                                       |   |  |  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY S<br>(EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO)<br>CROSS-REFERENCED TO THE APF<br>DEFICIENCY) | ULD BE COMPLETION                     |   |  |  |
|                          |                             | e most recent   |   |  |                                       | _ |  |  |
|                          | monthly rec                 | apitulation [March,   |   |  |                                       |   |  |  |
|                          | 2011.]                      |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |
|                          |                             |   |   |  |                                       |   |  |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                     | (X2) MULTIPLE CONSTRUCTION                                 |         |               | (X3) DATE SURVEY<br>COMPLETED                                      |            |                    |
|--|---------------------|--|---------|---------------|--|------------|--------------------|
| AND PLAN   | OF CORRECTION       | 155124   | A. BUII |               |  | 03/08/2011 |                    |
|  |                     |  | B. WIN  |               | ADDRESS, CITY, STATE, ZIP CODE                                     |            |                    |
| NAME OF F  | ROVIDER OR SUPPLIEF | R  |         |               | MAIN ST  |            |                    |
| VERMILL  | ION CONVALESC       | ENT CENTER   |         | CLINTO        | DN, IN47842  |            |                    |
| (X4) ID  |                     | STATEMENT OF DEFICIENCIES                                  |         | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |            | (X5)               |
| PREFIX<br>TAG  |                     | ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) |         | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)                     | ΓE         | COMPLETION<br>DATE |
| F0323  | 2. On 3/3/1         | 1 at 11:10 a.m.,   | F03     | 23            | The facility must ensure that the resident environment remains     |            | 03/28/2011         |
| SS=D   | 1                   |  |         |               | free of accident hazards as is                                     | as         |                    |
|  | to transfer R       | tesident #7 from the                                       |         |               | possible; and each resident receives adequate supervision          | 1          |                    |
|  | bed to the w        | heelchair utilizing  |         |               | and assistive devices to preve accidents. The facility feels it h  |            |                    |
|  |                     | Reliant 450 hoyer  |         |               | met this requirement through t following corrective measures:      | he         |                    |
|  |                     | lift. The resident   |         |               | Resident # 101,#7, and #61   | 1.         |                    |
|  | was observe         | ed to be lifted off  |         |               | suffered no actual harm.2. Residents who require the use           | e of       |                    |
|  | the surface of      | of the bed six   |         |               | a mechanical lift have the   |            |                    |
|  | inches and r        | emained at the   |         |               | potential to be affected.3. The policy and procedure for           | ;          |                    |
|  | same height         | when transferred   |         |               | mechanical lift use (See<br>Attachment D) and the lift             |            |                    |
|  | to the wheel        | chair. The resident  |         |               | manufacturer's instructions we                                     |            |                    |
|  | did not face        | the operator. CNA  |         |               | reviewed. The policy requires changes at this time. Licensed       |            |                    |
|  | #9 was obse         | rved to tip the  |         |               | and non-licensed nursing staff were re-educated regarding          |            |                    |
|  | locked whee         | elchair backwards  |         |               | both(See Attachment E) The   |            |                    |
|  | and grab the        | sling to pull  |         |               | Director of Nursing or designe will complete competency che        |            |                    |
|  | towards the         | back of the seat.  |         |               | offs for Mechanical Lift three times daily on scheduled work       |            |                    |
|  | The resident        | t was then lowered   |         |               | days for 2 weeks, then daily or                                    |            |                    |
|  | into the whe        | elchair.   |         |               | scheduled work days for two weeks, then weekly for four            |            |                    |
|  |                     |  |         |               | weeks, then monthly for two months, then quarterly (See            |            |                    |
|  | Review of the       | ne clinical record of                                      |         |               | Attachment F).4. The findings                                      | of         |                    |
|  | Resident #7         | on 3/2/11 at 11:30   |         |               | these audits will be reviewed during the facility's quarterly      |            |                    |
|  | a.m. indicate       | ed the most recent   |         |               | Quality Assurance meetings at the plan of action adjusted          | nd         |                    |
|  | Minimum D           | Pata Set (MDS) was   |         |               | accordingly.5. The above   |            |                    |
|  | completed 1         | /9/11. The   |         |               | corrective measures will be completed on or before 3/28/1          | 1.         |                    |
|  | assessment i        | identified the   |         |               | 35.11plotod 311 31 301010 3/20/11.                                 |            |                    |
|  |                     |  |         |               |  |            |                    |

| NAME OF PROVIDER OR SUPPLIER  VERMILLION CONVALESCENT CENTER  INS. 10 SUMMARY STATIMENT OF DEPERTMENTS  REGULATORY OR LSC IDENTIFYING DISPOSMATION)  TAG  resident required total dependence for transfers. An physician's order was noted dated 1/20/11 of resident to be hover lift only due to resident's non-compliance.   | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155124 |   |   | (X2) MULTIPLE CO  A. BUILDING  B. WING | NSTRUCTION   | ľ í   | E SURVEY<br>PLETED<br>2011 |
|--|--|---|---|--|--|-------|----------------------------|
| PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  resident required total dependence for transfers. An physician's order was noted dated 1/20/11 of resident to be hoyer lift only due to resident's  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OF LSC IDENTIFYING INFORMATION)  PREFIX TAG  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  COMPLETION DATE  COMPLETION DATE |  |   |   | 1705 S                                 | MAIN ST  | E     |                            |
| dependence for transfers. An physician's order was noted dated 1/20/11 of resident to be hoyer lift only due to resident's   | PREFIX   | (EACH DEFICIEN                                  | ICY MUST BE PERCEDED BY FULL                              | PREFIX                                 | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPI | LD BE | COMPLETION                 |
| physician's order was noted dated 1/20/11 of resident to be hoyer lift only due to resident's  |  | _   |   |  |  |       |                            |
|  |  | physician's of<br>dated 1/20/1<br>hoyer lift on | order was noted  1 of resident to be ly due to resident's |  |  |       |                            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                          | (X2) MULTIPLE CONSTRUCTION                               |                          |                               | (X3) DATE SURVEY   |            |                   |
|--|--------------------------|--|--------------------------|-------------------------------|--|------------|-------------------|
| AND PLAN   | OF CORRECTION            | IDENTIFICATION NUMBER:                                   | A. BUILDING              |                               |  | COMPLETEI  | D                 |
|  |                          | 155124   | B. WIN                   |                               |  | 03/08/2011 |                   |
| NAME OF I  | PROVIDER OR SUPPLIER     |  |                          |                               | ADDRESS, CITY, STATE, ZIP CODE   |            |                   |
| VERMILL  | ION CONVALESCE           | ENT CENTER   |                          | l                             | MAIN ST<br>DN, IN47842   |            |                   |
| (X4) ID  |                          | TATEMENT OF DEFICIENCIES                                 |                          | ID                            | PROVIDER'S PLAN OF CORRECTION  |            | (X5)              |
| PREFIX<br>TAG  | *                        | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |                          | PREFIX<br>TAG                 | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | E CO       | OMPLETION<br>DATE |
| F0323  |                          | 1 at 9:50 a.m., CNA                                      | F03                      |                               | The facility must ensure that the  | 1 00       | 3/28/2011         |
| SS=D   | #'s 1 and 2 tr           | ransferred Resident                                      |                          |                               | resident environment remains free of accident hazards as is                            | as         |                   |
|  | #61 from a               | geri-chair to bed  |                          |                               | possible; and each resident receives adequate supervision                              |            |                   |
|  | utilizing a "I           | nvacare Reliant  |                          |                               | and assistive devices to preve accidents. The facility feels it has                    | nt         |                   |
|  | 450." Prio               | r to lifting the   |                          |                               | met this requirement through t   | he         |                   |
|  | resident fron            | n the geri-chair,  |                          |                               | following corrective measures: Resident # 101,#7, and #61                              | 1.         |                   |
|  | CNA#1 lock               | ked the wheels on  |                          |                               | suffered no actual harm.2. Residents who require the use                               | of         |                   |
|  | the mechanic             | cal lift.  |                          |                               | a mechanical lift have the   |            |                   |
|  |                          |  |                          |                               | potential to be affected.3. The policy and procedure for                               |            |                   |
|  | Manufacture              | er's directions,   |                          |                               | mechanical lift use (See   |            |                   |
|  |                          | the DON on 3/8/11  |                          |                               | Attachment D) and the lift manufacturer's instructions we                              | re         |                   |
|  | •                        | ., included, but   |                          |                               | reviewed. The policy requires  | no         |                   |
|  | •                        | ted to: "When  |                          |                               | changes at this time. Licensed and non-licensed nursing staff                          |            |                   |
|  |                          | ustable base lift,                                       |                          |                               | were re-educated regarding both(See Attachment E) The                                  |            |                   |
|  |                          | ST BE in the   |                          |                               | Director of Nursing or designe   |            |                   |
|  |                          | PENED/LOCKED   |                          |                               | will complete competency che offs for Mechanical Lift three                            | CK         |                   |
|  |                          | FORE lifting the   |                          |                               | times daily on scheduled work  |            |                   |
|  | •                        |  |                          |                               | days for 2 weeks, then daily or scheduled work days for two                            | 1          |                   |
|  | _                        | ARNING Invacare  |                          |                               | weeks, then weekly for four weeks, then monthly for two                                |            |                   |
|  |                          | ecommend locking   |                          |                               | months, then quarterly (See  |            |                   |
|  |                          | asters of the patient                                    |                          |                               | Attachment F).4. The findings these audits will be reviewed                            | of         |                   |
|  |                          | ing an individual.                                       |                          |                               | during the facility's quarterly  | ,          |                   |
|  | _                        | uld cause the lift to                                    |                          |                               | Quality Assurance meetings at the plan of action adjusted                              | na         |                   |
|  | •                        | nger the patient   | accordingly.5. The above |                               | accordingly.5. The above corrective measures will be                                   |            |                   |
|  | and attendants. Invacare |  |                          | completed on or before 3/28/1 | 1.   |            |                   |
|  | DOES recon               | nmend that the rear                                      |                          |                               |  |            |                   |
|  | <u> </u>                 |  | 1                        |                               | L  |            |                   |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155124 |                      |   | IULTIPLE CO<br>LDING | NSTRUCTION          | COMPL  | LETED   |                            |
|---|----------------------|---|----------------------|---------------------|--|---------|----------------------------|
|   |                      | 155124  | B. WIN               |                     |  | 03/08/2 | 011                        |
| NAME OF F   | PROVIDER OR SUPPLIER |   |                      |                     | DDRESS, CITY, STATE, ZIP CODE  MAIN ST   |         |                            |
| VERMILL   | LION CONVALESCE      | ENT CENTER  |                      | 1                   | N, IN47842   |         |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN       | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE     | (X5)<br>COMPLETION<br>DATE |
|   | casters be le        | ft unlocked during  |                      |                     |  |         |                            |
|   | lifting proce        | dures to allow the  |                      |                     |  |         |                            |
|   | patient lift to      | stabilize itself  |                      |                     |  |         |                            |
|   | when the pat         | tient is initially  |                      |                     |  |         |                            |
|   | lifting from         | a chair, bed or any   |                      |                     |  |         |                            |
|   | stationary of        | oject When  |                      |                     |  |         |                            |
|   | moving the p         | patient lift away   |                      |                     |  |         |                            |
|   | from the bed         | l, turn patient /so   |                      |                     |  |         |                            |
|   | that he/she fa       | aces attendant  |                      |                     |  |         |                            |
|   | operating the        | e patient lift. Turn  |                      |                     |  |         |                            |
|   | crank handle         | counterclockwise  |                      |                     |  |         |                            |
|   | (manual) or          | open control valve  |                      |                     |  |         |                            |
|   | (hydraulic) l        | owering patient so  |                      |                     |  |         |                            |
|   | that his feet        | rest on or over the   |                      |                     |  |         |                            |
|   | base of the li       | ift, straddling the   |                      |                     |  |         |                            |
|   | mast. Close          | control valve.  |                      |                     |  |         |                            |
|   | NOTE: The            | lower center of   |                      |                     |  |         |                            |
|   |                      | ides stability  |                      |                     |  |         |                            |
|   |                      | patient feel more   |                      |                     |  |         |                            |
|   |                      | ne lift easier to pull  |                      |                     |  |         |                            |
|   |                      | OTE: DO NOT use   |                      |                     |  |         |                            |
|   | _                    | ing casters when  |                      |                     |  |         |                            |
|   | patient is in        | •   |                      |                     |  |         |                            |
|   | patient is in        | uic iiit.   |                      |                     |  |         |                            |
|   |                      |   |                      |                     |  |         |                            |

Facility ID:

|                          | OF CORRECTION  | IDENTIFICATION NUMBER:  155124  | A. BUII<br>B. WIN | LDING               | NSTRUCTION   | COMPI<br>03/08/2 | LETED                      |
|--------------------------|--|---|-------------------|---------------------|--|------------------|----------------------------|
|                          | PROVIDER OR SUPPLIER                                 |   | B. WIN            | 1705 S              | DDRESS, CITY, STATE, ZIP CODE MAIN ST N, IN47842   |                  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                       | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)     |                   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) |                  | (X5)<br>COMPLETION<br>DATE |
| IAU                      | The DON w 3/8/11 at 4:0 indicated it v policy not to | as interviewed on 00 p.m. The DON was the facility utilize lift pads frayed, or torn. |                   | IAU                 |  |                  | DATE                       |

|                                |   | X1) PROVIDER/SUPPLIER/CLIA                               | (X2) M                      | JLTIPLE CO   | ONSTRUCTION   | (X3) DATE SURVEY |                    |
|--------------------------------|---|--|-----------------------------|--|---|------------------|--------------------|
| AND PLAN                       | OF CORRECTION   | IDENTIFICATION NUMBER:                                   | A. BUII                     | A. BUILDING COMPLETE   |   |                  |                    |
|                                |   | 155124   | B. WIN                      |  |   | 03/08/20         | )11                |
| NAME OF F                      | PROVIDER OR SUPPLIER  |  |                             | l  | ADDRESS, CITY, STATE, ZIP CODE  |                  |                    |
| VERMILLION CONVALESCENT CENTER |   |  |                             | 1705 S MAIN ST<br>CLINTON, IN47842   |   |                  |                    |
| (X4) ID                        | SUMMARY STATEMENT OF DEFICIENCIES   |  |                             | ID   | PROVIDER'S PLAN OF CORRECTION   |                  | (X5)               |
| PREFIX<br>TAG                  | `   | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |                             | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |   |                  | COMPLETION<br>DATE |
| F0371                          | Based on observation, record  |  | F03                         |  | No residents were affected     All residents have the potentia  |                  | 03/28/2011         |
| SS=E                           | review and i  |  |                             |  | be affected. The top of the ice machine was immediately   |                  |                    |
|                                | facility failed   | d to ensure ice was                                      |                             |  | cleaned. 3. The facility  |                  |                    |
|                                |   | r sanitary condition                                     |                             |  | presented an in-service on cleaning stainless steel and   |                  |                    |
|                                |   | e machine in that  |                             |  | sanitation terminology. (See attached Policy #G, and inserv   | <sub>/ice</sub>  |                    |
|                                |   | hine was observed  |                             |  | sign-in sheets(Attachment H). revised cleaning schedule was   | Α                |                    |
|                                | to have a bla   |  |                             |  | posted and is being monitored   |                  |                    |
|                                | substance on the inside top of the machine. This affected the 49 residents on the northside of the building.  the dietary mana weekly for two we weekly times 2 w monthly as part of going Quality As Program (See At |  | the dietary manager 5 times | es   |   |                  |                    |
|                                |   |  |                             |  | weekly times 2 weeks, then  |                  |                    |
|                                |   |  |                             | monthly as part of the facility's on going Quality Assurance                             |   |                  |                    |
|                                |   |  |                             |  | Program (See Attachment I).4  |                  |                    |
|                                | Findings inc  | lude:  |                             |  | The findings of these audits w be reviewed during the facility quarterly Quality Assurance meeting and the plan of action adjusted accordingly.5. The | 's               |                    |
|                                | During General Observation tour on 3/8/11 with the  |  |                             |  | above corrective actions will b completed on or before 3/28/1   |                  |                    |
|                                |   | e Supervisor and   |                             |  |   |                  |                    |
|                                |   | ng Supervisor,   |                             |  |   |                  |                    |
|                                | •   | d at 1:30 p.m., the                                      |                             |  |   |                  |                    |
|                                |   | on the north unit  |                             |  |   |                  |                    |
|                                | was noted w   | ith a black/brown  |                             |  |   |                  |                    |
|                                | substance on  | the edge of the  |                             |  |   |                  |                    |
|                                | plastic insert  | t at the top of the                                      |                             |  |   |                  |                    |
|                                | inside of the   | ice machine.   |                             |  |   |                  |                    |
|                                |   |  |                             |  |   |                  |                    |
|                                |   |  |                             |  |   |                  |                    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155124 |                | (X2) MULTIPLE CC  A. BUILDING  B. WING  | NSTRUCTION          | (X3) DATE<br>COMPI<br>03/08/2   | LETED    |                            |
|---|----------------|---|---------------------|---|----------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  VERMILLION CONVALESCENT CENTER  |                |   | 1705 S              | ADDRESS, CITY, STATE, ZIP CODE<br>MAIN ST<br>DN, IN47842  | <b>I</b> |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | BE       | (X5)<br>COMPLETION<br>DATE |
|   | During inter   | view of the   |                     |   |          |                            |
|   | Maintenance    | e Supervisor on   |                     |   |          |                            |
|   | 3/8/11 at 2 p  | o.m., the supervisor  |                     |   |          |                            |
|   | indicated the  | e maintenance   |                     |   |          |                            |
|   | department     | was responsible for   |                     |   |          |                            |
|   | cleaning and   | I sanitizing the ice  |                     |   |          |                            |
|   | machine.       |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   | During inter   | view of the   |                     |   |          |                            |
|   |                | e Supervisor on   |                     |   |          |                            |
|   | 3/8/11 at 2:3  | -   |                     |   |          |                            |
|   | •              | ndicated the last   |                     |   |          |                            |
|   | time north io  | ce machine had  |                     |   |          |                            |
|   | been cleaned   | d was on 1/12/11.   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   | 3.1-21(i)(3)   |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |
|   |                |   |                     |   |          |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |   | (X2) MULTIPLE CONSTRUCTION    |                  | (X3) DATE SURVEY                                       |  |  |                    |  |
|---|---|-------------------------------|------------------|--|--|--|--------------------|--|
| AND PLAN  | OF CORRECTION   | IDENTIFICATION NUMBER: 155124 | A. BUILDING      |  | COMPLETED 03/08/2011   |  |                    |  |
|   |   | 100124                        | B. WIN           |  | ADDRESS, CITY, STATE, ZIP CODE                                     | 03/00/2  | V11                |  |
| NAME OF P   | PROVIDER OR SUPPLIER  | 2                             |                  | l  | MAIN ST  |  |                    |  |
| VERMILL   | ION CONVALESC   | ENT CENTER                    | CLINTON, IN47842 |  |  |  |                    |  |
| (X4) ID<br>PREFIX                                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL   |                               |                  | ID<br>PREFIX   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |  | (X5)<br>COMPLETION |  |
| TAG   |   | LSC IDENTIFYING INFORMATION)  |                  | TAG  | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)                     | ΓE   | DATE               |  |
| F0494   | Based on re   | ecord review and              | F04              | 94   | The facility will ensure this requirement is met through the       | e  | 03/28/2011         |  |
| SS=D  | interview the facility failed   |                               |                  |  | following corrective measures:                                     | ving corrective measures:1. sidents were harmed. Staff |                    |  |
|   | to ensure a   | ll individuals                |                  | member #5's employment was terminated. Staff member #6 |  |  |                    |  |
|   | working in the facility as a  |                               |                  |  | resigned her positon.2. All  |  |                    |  |
|   | nurse aide for more than 4 months on a full-time basis had completed a training and competency evaluation program and/or deemed competent for 2 of 45 CNAs employed by the facility in that CNAs #5 |                               |                  |  | residents have the potential to affected. A thorough review of     | fall   |                    |  |
|   |   |                               |                  |  | employee files was conducted ensure appropriate certification      | n or<br>t the  |                    |  |
|   |   |                               |                  |  | licensure has been retained at facility and that all employees     |  |                    |  |
|   |   |                               |                  |  | hold said credentialing within a days of employment.3. Huma        |  |                    |  |
|   |   |                               |                  |  | Relations staff and the Directo<br>Nursing were be re-educated     |  |                    |  |
|   |   |                               |                  |  | hiring requirements (See<br>Attachment J). The Administra          |  |                    |  |
|   |   |                               |                  |  | or her designee will audit all prospective employees'              |  |                    |  |
|   |   |                               |                  |  | information provided prior to hiring to ensure criteria are        |  |                    |  |
|   | and #6 were working in the  |                               |                  | met(See Attachment K).4. The                           | е  |  |                    |  |
|   | facility as nurse aides for   |                               |                  |  | results of these audits will be reviewed during the facility's     |  |                    |  |
|   | more than   | more than 4 months and did    |                  |  | quarterly Quality Assurance meeting and the plan of action         |  |                    |  |
|   | not have a  | current Indiana               |                  |  | adjusted accordingly.5. The above corrective actions will b        | oe   |                    |  |
|   | CNA regist  | try certification.            |                  |  | completed on or before March 2011.                                 |  |                    |  |
|   | Findings in   | nclude:                       |                  |  |  |  |                    |  |
|   | 1. Review of the personnel  |                               |                  |  |  |  |                    |  |
|   | file of CNA # 5 on 3/8/11 at  |                               |                  |  |  |  |                    |  |
|   |   |                               |                  |  |  |  |                    |  |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |       |                     | COMPLETED   |         |                            |
|---|--------------------------------|---|-------|---------------------|---|---------|----------------------------|
|   |                                | 155124  | B. WI |                     |   | 03/08/2 | 2011                       |
| NAME OF I                                     | PROVIDER OR SUPPLIER           |   |       |                     | DDRESS, CITY, STATE, ZIP CODE   |         |                            |
| VERMILI                                       | VERMILLION CONVALESCENT CENTER |   |       | 1                   | NAIN 31<br>DN, IN47842  |         |                            |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIEN                 | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE .    | (X5)<br>COMPLETION<br>DATE |
|   | 4 p.m. ind                     | icated the CNA  |       |                     |   |         |                            |
|   | had been h                     | ired as a nurse   |       |                     |   |         |                            |
|   | aide on 7/2                    | 1/10. The   |       |                     |   |         |                            |
|   | personnel f                    | file contained  |       |                     |   |         |                            |
|   | information                    | n that the CNA  |       |                     |   |         |                            |
|   | had comple                     | eted the nurse  |       |                     |   |         |                            |
|   | aide trainin                   | ig competency   |       |                     |   |         |                            |
|   | evaluation                     | program in  |       |                     |   |         |                            |
|   | Illinois on                    | 9/21/2001. A  |       |                     |   |         |                            |
|   | current Inc                    | diana CNA   |       |                     |   |         |                            |
|   | registry cer                   | tification was  |       |                     |   |         |                            |
|   | lacking.                       |   |       |                     |   |         |                            |
|   | Interview o                    | of the  |       |                     |   |         |                            |
|   |                                | ator on 3/8/11 at   |       |                     |   |         |                            |
|   |                                |   |       |                     |   |         |                            |
|   | 1 *                            | ndicated CNA #5   |       |                     |   |         |                            |
|   |                                | mployed as a  |       |                     |   |         |                            |
|   |                                | for more than 4   |       |                     |   |         |                            |
|   |                                | d that she did not  |       |                     |   |         |                            |
|   |                                | rent Indiana CNA  |       |                     |   |         |                            |
|   | registry cer                   | tification.   |       |                     |   |         |                            |
|   |                                |   |       |                     |   |         |                            |
|   |                                |   |       |                     |   |         |                            |

PRINTED: 04/01/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION |                           | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:     |        | (X2) MULTIPLE CONSTRUCTION |   |    | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---------------------------|--|--------|----------------------------|---|----|-------------------------------|--|
|   |                           | 155124   | - 1    | A. BUILDING B. WING        |   |    | 03/08/2011                    |  |
| NAME OF P   | PROVIDER OR SUPPLIER      |  |        | 1                          | ADDRESS, CITY, STATE, ZIP CODE  | ļ. |                               |  |
| VERMILLION CONVALESCENT CENTER                    |                           |  |        | 1                          | MAIN ST<br>DN, IN47842  |    |                               |  |
| (X4) ID   | SUMMARY S                 | TATEMENT OF DEFICIENCIES                                 | $\neg$ | ID                         | PROVIDER'S PLAN OF CORRECTION   |    | (X5)                          |  |
| PREFIX<br>TAG                                     | · ·                       | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |        | PREFIX<br>TAG              | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | JΈ | COMPLETION<br>DATE            |  |
| Mo  |                           | of the personnel   |        | 1710                       | <u> </u>  |    | DATE                          |  |
|   |                           | A #6 on 3/8/11 at  |        |                            |   |    |                               |  |
|   |                           | cated the CNA  |        |                            |   |    |                               |  |
|   | •                         | ired as a nurse  |        |                            |   |    |                               |  |
|   | aide on 5/1               | 2/10. The  |        |                            |   |    |                               |  |
|   | personnel f               | ïle contained  |        |                            |   |    |                               |  |
|   | information               | n that the CNA   |        |                            |   |    |                               |  |
|   | was enrolled in a college |  |        |                            |   |    |                               |  |
|   | nursing pro               | gram. A current  |        |                            |   |    |                               |  |
|   | Indiana CN                | IA registry  |        |                            |   |    |                               |  |
|   | certification             | n was lacking.   |        |                            |   |    |                               |  |
|   | <b>.</b>                  | 0.1  |        |                            |   |    |                               |  |
|   | Interview of              |  |        |                            |   |    |                               |  |
|   | Administra                | tor on $3/8/11$ at                                       |        |                            |   |    |                               |  |
|   | 4:40 p.m. ii              | ndicated CNA #6  |        |                            |   |    |                               |  |
|   | had been en               | mployed as a   |        |                            |   |    |                               |  |
|   | nurse aide                | for more than 4  |        |                            |   |    |                               |  |
|   | months and that she had   |  |        |                            |   |    |                               |  |
|   | completed                 | fundamentals of  |        |                            |   |    |                               |  |
|   | nursing in 1              | ner nursing  |        |                            |   |    |                               |  |
|   | _                         | The Administrator  |        |                            |   |    |                               |  |
|   | •                         | nat she did not  |        |                            |   |    |                               |  |
|   |                           |  |        |                            |   |    |                               |  |

Facility ID:

PRINTED: 04/01/2011 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER OR SUPPLIER  VERMILLION CONVALESCENT CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  1705 S MAIN ST  CLINTON, IN47842     | 24 B. WING 03/08/2011  |         |
|---|--|---------|
| 1   | STREET ADDRESS, CITY, STATE, ZIP CODE 1705 S MAIN ST   |         |
| PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION (EACH CORRECTION COMP) CROSS-REFERENCED TO THE APPROPRIATE COMP) | BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETIO | PLETION |
| CROSS-REFERENCED TO THE APPROPRIATE   | ndiana CNA ation.  tor indicated ty's policy king as a ld have egistry thin the 120 of hire.               |         |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI  COMPLET  A. BUILDING |              | ETED   |          |                    |
|---|----------------------|---|--|--------------|--|----------|--------------------|
|   |                      | 155124  | B. WIN   |              |  | 03/08/20 | 011                |
| NAME OF F                                     | PROVIDER OR SUPPLIER |   |  |              | ADDRESS, CITY, STATE, ZIP CODE   |          |                    |
|   | LION CONVALESCE      | ENT CENTER  | 1705 S MAIN ST<br>CLINTON, IN47842                             |              |  |          |                    |
| (X4) ID<br>PREFIX                             |                      | TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL |  | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE   |          | (X5)<br>COMPLETION |
| TAG   | `                    | LSC IDENTIFYING INFORMATION)                          |  | TAG          | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)   | E        | DATE               |
| F0516   | Based on ob          | oservation, record                                    | F05  | 16           | The facility will ensure this requirement is met through the   |          | 03/28/2011         |
| SS=E  | review and is        | nterview the  |  |              | following corrective measures:   | 1.       |                    |
|   | facility failed      | d to safeguard 12                                     |  |              | No residents were harmed.2. residents have the potential to  |          |                    |
|   | of 12 plastic        | totes containing                                      |  |              | affected.3. Medical records  |          |                    |
|   | discharged n         | nedical records                                       |  |              | personnel and Maintenance<br>Supervisor were re-educated of  |          |                    |
|   | from unauth          | orized use in that                                    |  |              | the policy regarding safeguard of clinical records (See  | ing      |                    |
|   | clinical reco        | rds were stored in a                                  |  |              | Attachment L). The administra  | ator     |                    |
|   | storage shed         | , which the   |  |              | or her designee will monitor clinical records storage three  |          |                    |
|   | maintenance          | person had keys                                       |  |              | times weekly for four weeks, then  | nen      |                    |
|   | to.                  |   |  |              | monthly for three months, ther   |          |                    |
|   | Findings inc         |   |  |              | quarterly (See Attachment M). Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meeting.5. The above correct measures will be completed or | ive      |                    |
|   | _                    | eral Observation                                      |  |              | before 3/28/11.  |          |                    |
|   | tour on 3/8/1        |   |  |              |  |          |                    |
|   |                      | e Supervisor, which                                   |  |              |  |          |                    |
|   | began at 1:30        | 0 p.m., the   |  |              |  |          |                    |
|   | supervisor u         | sed a key on his                                      |  |              |  |          |                    |
|   | key ring to o        | pen a storage shed.                                   |  |              |  |          |                    |
|   | Twelve large         | e plastic totes were                                  |  |              |  |          |                    |
|   | observed. Th         | ne Supervisor   |  |              |  |          |                    |
|   | indicated the        | totes contained                                       |  |              |  |          |                    |
|   | discharged re        | esidents' medical                                     |  |              |  |          |                    |
|   | records.             |   |  |              |  |          |                    |
|   |                      |   |  |              |  |          |                    |
|   |                      |   |  |              |  |          |                    |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155124 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING   | ONSTRUCTION         | (X3) DATE SURVEY COMPLETED 03/08/2011   |                      |
|--|--|--|---------------------|---|----------------------|
|  | NAME OF PROVIDER OR SUPPLIER  VERMILLION CONVALESCENT CENTER   |  |                     | ADDRESS, CITY, STATE, ZIP CODE  MAIN ST ON, IN47842   | l                    |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| !  | During inter   | view of the  |                     |   |                      |
|  | Administrate   | or on 3/8/11 at 2:25   |                     |   |                      |
|  | p.m., the Ad   | ministrator  |                     |   |                      |
|  | indicated the  | e Maintenance  |                     |   |                      |
|  | Supervisor v   | vas not a licensed   |                     |   |                      |
|  | person author  | orized to have   |                     |   |                      |
|  | access to the  | records and  |                     |   |                      |
|  | should not h   | ave access to  |                     |   |                      |
|  | medical reco   | ords.  |                     |   |                      |
|  | During revie<br>policy titled<br>RECORDS 3<br>3/8/11 at 2:2<br>indicated "C<br>be safeguard<br>destruction a | ew of a facility "MEDICAL POLICY", on 5 p.m., the policy linical records will led against loss, and unauthorized ag in file cabinets |                     |   |                      |